

HEALTH CARE FRAUD AND ABUSE PROPOSALS

SUBSTANTIVE CHANGES - Medicaid Fraud

- 1) State False Claims Act for Medicaid
Allow individuals in a position to know about ongoing fraud to file an action on behalf of the state. The Attorney General would have an opportunity to intervene in that action and proceed against the alleged perpetrator. A number of states, including Texas and Virginia, have seen an increase in referrals as a result of their False Claims Acts.
- 2) Require pharmaceutical companies to disclose and certify under penalty of perjury Their “Average Manufacturer’s Price” (AMP) and “Average Sales Price” (ASP) to Division of Medical Services on a monthly basis. This reporting requirement is in addition to existing reporting requirements.
- 3) Allow *permissive* aggregation of false claims, rather than each being considered a separate offense
As currently provided in 191.905.8. Presently, each false submission is a D felony. Receipt of funds is not an element. Such a change could accommodate C and B felonies based on value for making a false claim ***and*** receiving Medicaid funds.

Also, add language to Section 191.905.7 stating that amounts taken from a resident pursuant to a scheme or course of conduct may be aggregated - this would allow for enhanced penalties in certain cases.
- 4) Create offense for obstruction of Medicaid Fraud Control Unit (MFCU) audit
To include making false statements to MFCU auditor. Compare with 18 USC 1516.
- 5) Create offense for obstruction of MFCU investigation
To include making false statements to MFCU investigator. Compare with 18 USC 1518.
- 6) Create offense for health care provider failing to maintain adequate records.
- 7) Create offense of knowingly destroying or concealing records.
- 8) Amend Section 1.020(11) to add “and to other legal entities” to definition of person.

SUBSTANTIVE CHANGES - Nursing Home Abuse/Neglect

- 1) Authorize civil monetary penalties for violations of Class II Standards without an opportunity to avoid penalty because that violation is corrected at the time of reinspection

Class II standard - violation of standard which has a direct or immediate relationship to the health, safety or welfare of any resident, but which does not create imminent danger.

2) Increase the “per bed” civil penalty and cap in those cases where the violation results in serious physical injury or sexual abuse to residents - current cap is \$100/bed with a maximum penalty of \$10,000.

New penalty of \$1,000/bed with a maximum penalty of \$75,000.

3) Provide residents with a better opportunity to file a complaint with the Attorney General if a nursing home is denying or ignoring their rights as a resident.

Section 198.090 provides residents of nursing homes with a variety of rights - if a nursing home violates those rights, the resident may file a complaint with the Attorney General. Current law allows only 180 days to file the complaint. Expanding the time period to 2 years would provide a better opportunity for residents, or their estates, to refer cases to the Attorney General that would otherwise be time barred.

4) Allow for prosecutions based on “reckless” conduct in addition to knowing conduct.

“Reckless” (198.070.13) - Person consciously disregards a substantial and unjustifiable risk that the person’s conduct will result in serious physical injury and such disregard constitutes a gross deviation from the standard of care that a reasonable person would exercise in the situation.

Make the same change to Section 660.300.12 for home health clients.

SUBSTANTIVE CHANGES - Elder Abuse

1) In nursing home context, define “abuse” (198.006) to include financial crimes against the resident. Also, make the same definition change in Section 660.250(1) as it relates to home health clients. Current law limits abuse to “infliction of physical, sexual or emotional injury or harm” or, in home health context, includes “financial exploitation” but not other financial crimes.

2) Amend elder abuse, 2nd degree (565.182), by requiring that a prosecutor show that a person “recklessly” causes serious physical injury. This crime would be a class C felony.

Current law requires the prosecutor to show that the conduct was “reckless and purposeful”. These two conflicting standards for the same crime make it virtually impossible to prosecute today.

3) Require that when the Department of Social Services substantiates a report of elder abuse, the Department shall notify the Attorney General (565.186).

PROCEDURAL/INVESTIGATIVE TOOLS

- 1) Make statute of limitations for crime of Medicaid fraud 10 years rather than 3. Clarify statute of limitations regarding civil remedies for Medicaid fraud (double damages, treble damages, civil monetary penalties – to be called civil monetary damages) to be 10 years.
- 2) In addition to present venue provisions, make venue for prosecuting Medicaid fraud (both civil and criminal) to be either the county from which the claim was submitted (generally, where the provider bills from) or where the claim was received or acted upon (now Cole County).
- 3) Grant MFCU right of immediate access and presence at any facility of an enrolled provider with automatic exclusion from the Medicaid program for failure to grant access. Compare 42 CFR 1001.1301.
- 4) Provide for special health care fraud subpoena requiring production within 24 hours. Failure to comply results in automatic exclusion from the Medicaid program.